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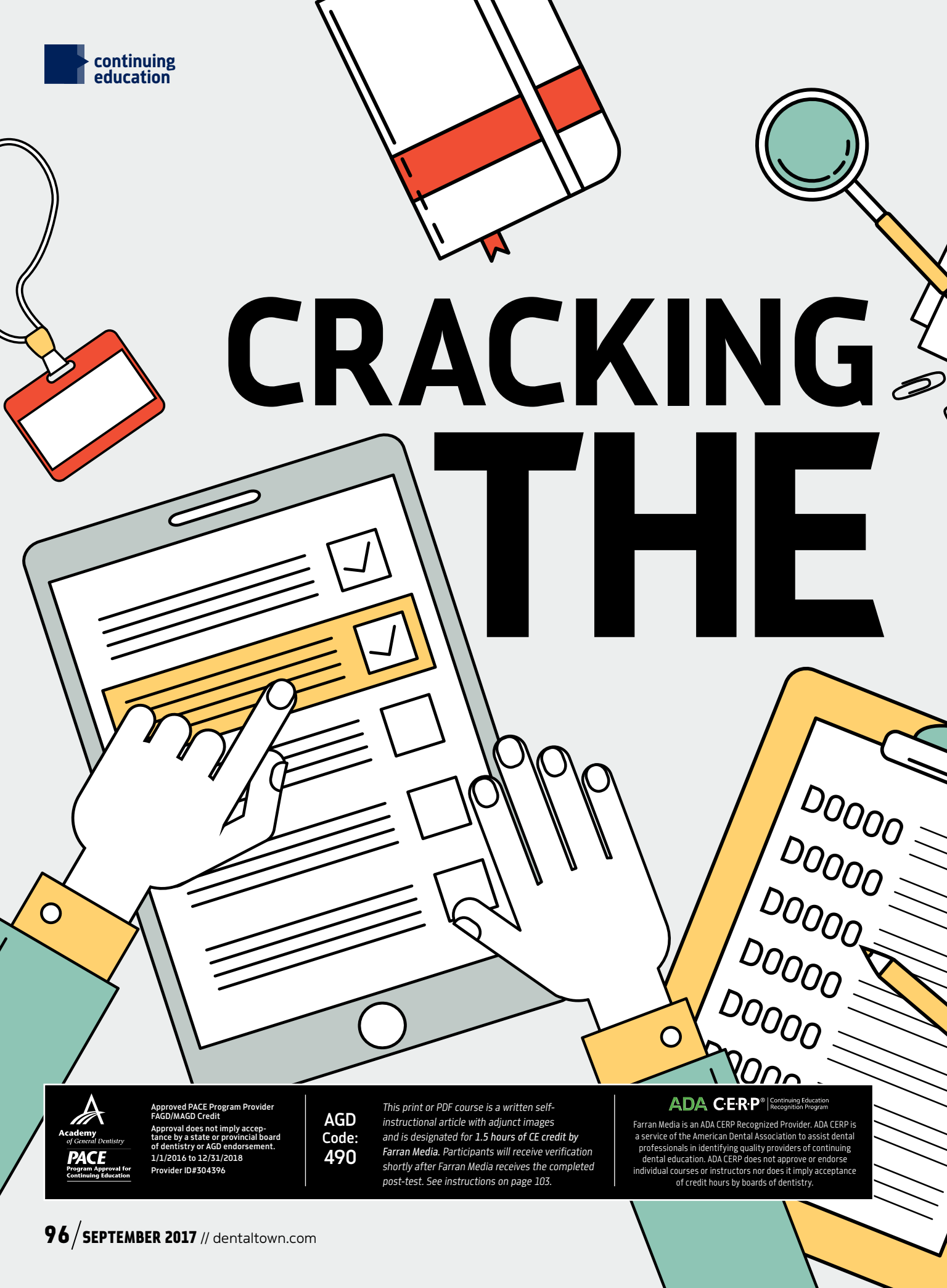

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CODE

A look at ***expanded CDT coding*** *as a means to better dentistry*

by Patti DiGangi, RDH, BS

Patti DiGangi, RDH, BS, is an international speaker who works with dental professionals to improve practice profitability. Her work helps dental professionals embrace the opportunities and understand the metrics that accurate insurance coding provides. The ADA recognized her expertise by inviting her to write a chapter in its *CDT 2017 Companion* book and again for *CDT 2018 Companion*. She holds publishing and speaking licenses with ADA for Current Dental Terminology 2017 and a license for SNODENT 2017 diagnostic coding. She is the author of the *DentalCodeology* series. DiGangi can be reached at patti@dentalcodeology.com.

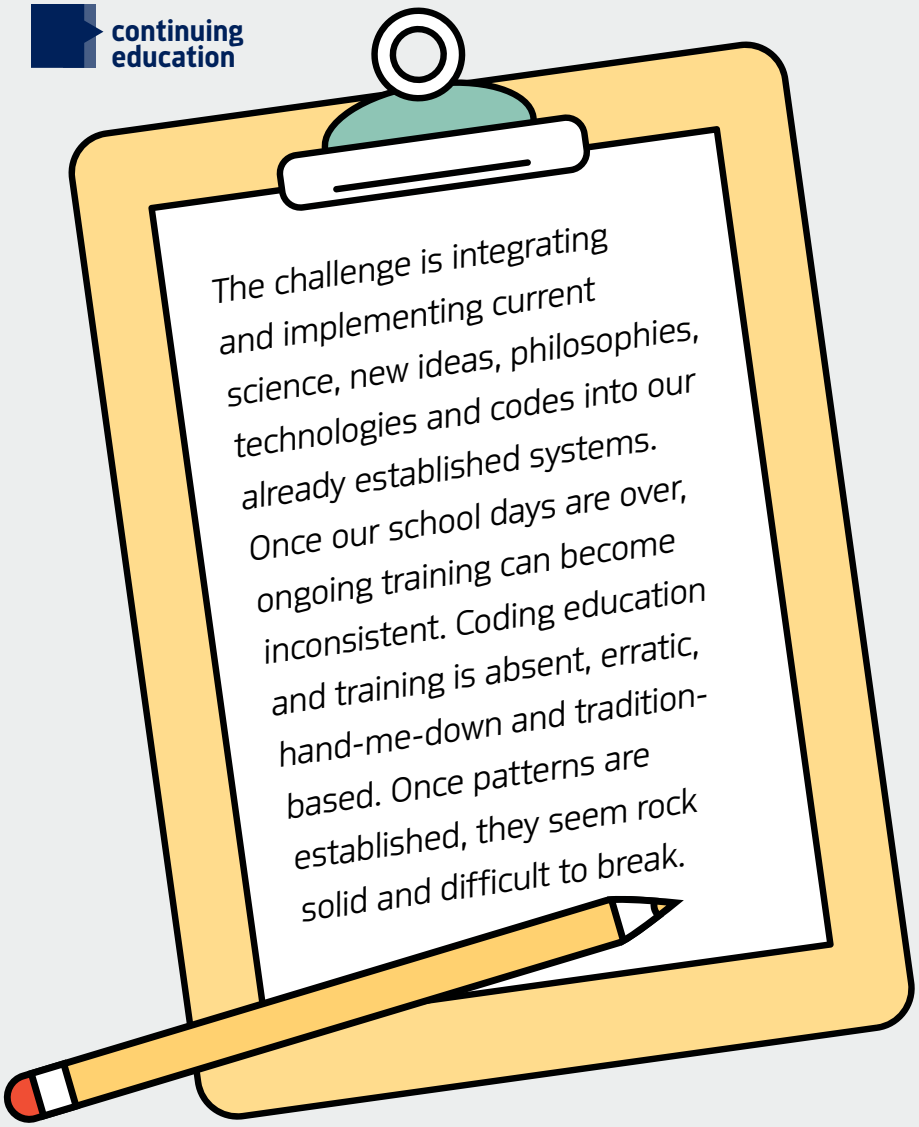
Course description

This course explores how current dental terminology (CDT) code gaps have contributed to a delay in therapeutic care of early periodontal disease, recognition of its medical relevance, and the communication between dental and medical professionals. With more than 29 million Americans living with diabetes and 86 million people living with prediabetes, codes for chairside HbA1c testing, treatment of gingival inflammation and teledentistry have the potential to significantly improve interdisciplinary health care.

Abstract

New codes can potentially close the loop and elevate our standard of care. For example, a new code exists for the treatment of gingivitis after decades of merely dumping gingival inflammation into the same category as health. With increasing research pointing to the connection between oral disease and medical conditions, the timing is perfect. Early recognition encourages intervention and disease prevention. For example, a simple chairside HbA1c glucose screening via finger-stick can be used to rapidly identify high-risk patients.

A code for the finger-stick can assist in broader adoption in dental practices. With a staggering number of Americans with diabetes and prediabetes, the oral/systemic inflammation creates a cascade



of other health issues. Earlier treatment of people beyond the walls of traditional dental practices is paramount.

Teledentistry is a rising trend and an expansion beyond the physical limitations of the traditional dental practice, and will have CDT codes in 2018.

The question is: Why does it take new codes for dentistry to change our deeply held behavior patterns?

Learning objectives

After reading this article, participants should be able to:

1. Recognize the influence of CDT coding in dental practices.
2. Identify the tridirectional relationship with oral disease.
3. Categorize the decade's trends in periodontics to understand the influence on behavior patterns and code sets.
4. Demonstrate how teledentistry can increase access to care and practice revenue.
5. Consider strategic thinking, step-by-step planning and small daily choices and their impact on outcomes.

New codes create change and profit opportunities

How many truly healthy patients do we see? If we are honest, the number is low. Most patients present with some level of active disease. Performing preventive procedures to reduce the likelihood of disease does not make sense when disease is already present, yet that tradition remains for most practices.

We know procedure codes should not dictate treatment. Gaps in the CDT codes have contributed to this reality. For example, D4346 was added to CDT 2017 and is a game-changer code, because it assists dental clinicians in reporting and treating the gingival inflammation disease *before* bone loss occurs.

A new CDT code planned for 2018 reflects the increasing role dental health professionals can play beyond a patient's oral care and within overall systemic health.[1] The code relates to an in-office measure of hemoglobin HbA1c, a blood test that provides information about a person's average circulating blood sugar levels for the previous three months.

Teledentistry, the use of health information exchanged from one site to another via electronic communications to improve a dental patient's clinical status, will also have codes in *CDT 2018*.[1]

The CDT code gaps contribute to the delay of therapeutic care of early periodontal disease, recognition of its medical relevance and the communication between dental and medical professionals. New codes may also incentivize dental professionals to consider adding important services. Yet this information on these oral/systemic relationships is not new. Why did it take a new procedure code to consider offering these services?

HbA1c testing

"People with poorly controlled diabetes are at greater risk for dental problems. High blood sugar may cause dry mouth and make gum disease worse. There is a definite link of oral health to overall health, and dentists are often on the front lines of investigating systemic health."[1]

More than 29 million Americans are living with diabetes, and up to 25 percent

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of U.S. adults who have diabetes don't know that they have it or that they could be developing serious complications. Eighty-six million people are living with prediabetes, and up to 90 percent of those individuals are unaware of their condition.[2] These facts indicate that widespread blood glucose screening may provide high value to our health care system. Dentistry can help.

Diabetes is a disease that has been demonstrated to have a tridirectional relationship with oral disease, specifically periodontitis, and metabolic syndrome. Metabolic syndrome is a set of risk factors for cardiovascular diseases, such as visceral obesity, dyslipidemia, high hypertension, glucose intolerance and insulin resistance, which frequently present together.[3]

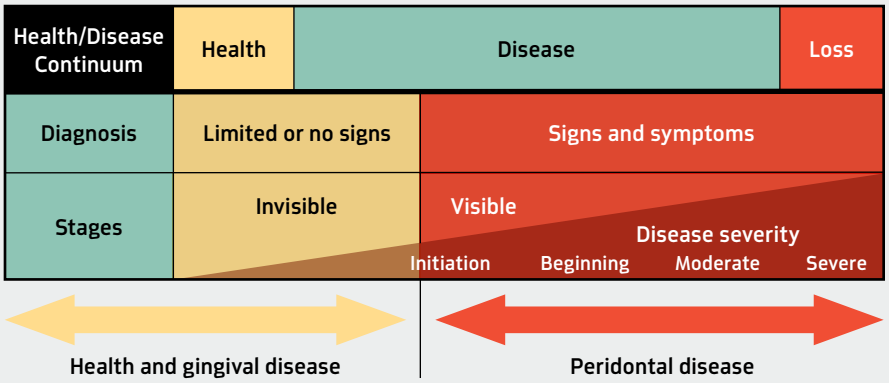
Recognizing metabolic syndrome has generally been a guessing game. There is not a unique designation for it on patient health histories. These risk factors and the tridirectional connections with oral disease make recognition a pivotal factor in the health and disease state of our patients.

It's probably not possible for proper periodontal health and disease management without considering these risk factors.

This relationship suggests dental visits could offer a largely untapped opportunity to screen for undiagnosed diabetes and prediabetes. It is relevant for dental professionals to be able to assess patients for diabetic status, particularly undiagnosed patients with risk factors. Dental office screening for diabetes and prediabetes may encourage increased interprofessional collaboration to achieve a more integrated patient care model in which dental health care professionals work together with medical colleagues to share in the health management of patients with diabetes.[4]

A simple chairside HbA1c glucose screening via finger-stick can be used to rapidly identify high-risk patients. The higher the HbA1c level, the poorer the blood sugar control and the higher risk of diabetes complications. A code for the finger-stick HbA1c glucose test procedure can assist in broader adoption of this in dental practices.

Studies suggest that improved diagnosis and control of diabetes mellitus may be achieved through implementation of blood glucose testing in dental practices.[4-6] Chairside screening may improve diagnosis, thus bringing dental professionals fully into the medical management team.



A specific CDT code creates a metric. Metrics collected by code usage create data based on outcomes. This data becomes the basis for decisions made for generating research grants, developing appropriate insurance plans, and collaborative care.[7]

As I mentioned earlier, the new code may incentivize dental professionals to consider adding important services such as this one. Yet why did it take a new procedure code to consider offering these services?

New definition for perio

Before we can fully discuss the influence of the D4346 gingival inflammation code, we need to be clear on the definition of the periodontal continuum, which has come to mean periodontitis and bone loss.

The chart above shows the continuum of health to disease. Our traditional model has been about finding and treating disease. At the same time, every practitioner knows there are levels of health.

Again, codes have influenced this thinking. The CDT procedure codes' names and descriptions are based on a 1955–1965 calculus theory.

Table 1 shows the evolution of periodontal theory, yet the codes are stuck in language from 1955–1965. Dental professionals' language and behavior is a mishmash between talking about biofilm, killing as many bugs as possible and following the golden rule of flossing in an attempt to help the patient achieve optimal oral health—a goal as elusive as world peace.

Microbiome research fueled by advances in genomic technologies, such as next-generation DNA sequencing, allows researchers to gain a better understanding of the complex communities of microbes in the human body.[9] This data questions the ideas of specific pathogens versus pathogenic biofilms working as communities. The resulting inflammation creates multifaceted challenges to the host body.[10]

Every dental professional sees gingival inflammation. Whether it's the hygienist seeing patients for routine care or dentists

Table 1

Decade Trends in Periodontics[8]		
1955–1965	Calculus theory	Plane those roots
1965–1975	Nonspecific plaque theory	If everyone flossed, we would have "world peace"
1975–1990	Bacterial specificity era	Kill all the bugs
1991–2013	Host/bacterial ecological interaction theory	Biofilm disruption
2013–current	Microbial dysbiosis[6]	Microbiome balancing

performing restorative care, we know the health of gingival tissues is important with inflammation recognized as a catalyst of the oral/systemic link. Yet, our tradition has been to think and behave as if it is not significant until major destruction occurs.

This behavior is somewhat akin to knowing a person has high blood pressure, yet waiting until there is heart attack before the disease process is viewed as serious.

From a perio perspective, before there is clinical attachment loss, there are signs and symptoms of oral inflammation that have been treated with measures meant for prevention.

We can finally treat gingivitis, after decades of merely dumping gingival inflammation into the same category as health. This new code can potentially close the loop and elevate our standard of care.

With increasing research pointing to the connection between oral disease and medical conditions, the timing is perfect. Early recognition ensures earlier intervention and disease prevention.[11]

The D4346 code facilitates accurate coding for care we have been performing routinely. As with other new codes, the D4346 code creates a metric, and metrics collected by code usage create data based on outcomes.

Teledentistry coding opportunities

The rising trend of teledentistry is an expansion beyond the physical limitations of the traditional dental practice. Patients can now have a virtual dental home in addition to a physical one.

Teledentistry can increase access to care and revenue streams by providing profitable outreach to the community without adding more chairs. Using technology, dental professionals can screen, record, triage, diagnose and order care to be performed remotely. Patient outcomes can be like visiting a brick-and-mortar dental office.

Teledentistry, according to the ADA's "Comprehensive Policy Statement on Teledentistry," refers to four types of telehealth systems in dentistry:[12]

- **Remote patient monitoring (RPM)**: Personal health and medical data collection from an individual in one location via electronic communication technologies, which is transmitted to a provider (sometimes via a data processing service) in a different location for use in care and related support of care.
- **Mobile health (mHealth)**: Health care and public health practice and education supported by mobile communication devices such as cellphones, tablet computers and personal digital assistants.
- **Live video (synchronous)**: Live, two-way interaction between a patient, caregiver or provider and a provider using audiovisual telecommunications technology.

- **Store-and-forward (asynchronous)**: Transmission of recorded health information such as radiographs, photographs, video, digital impressions and photomicrographs through a secure electronic communications system to a practitioner, who uses the information to evaluate a patient's condition or render a service outside of a real-time or live interaction.[13]

Two of the four—synchronous and asynchronous modalities—were granted CDT 2018 codes. An ADA Ad Hoc workgroup is developing a guide for the use of these new teledentistry codes as they did for D4346 in 2016.[14]

Intraoral cameras are proven tools for boosting patient awareness and case acceptance. An oral digital tour has become common practice for many professionals. There are a wide variety of systems available but not all are ready for the changing world of teledentistry. Barriers in the form of cost, design, portability and HIPAA compliance still exist.

The type of technology chosen and the solutions provider selected are paramount. Not all collaboration technology is equal; it needs to provide seamless communication in real time while being easy to use. Poor connections, confusing technology or inferior technology can render teledentistry inefficient.

Systems designed with an eye for teledentistry are emerging on the market. They include video conferencing services like Vidyo, VSGi and more. Virtual Dental Care and Planet DDS offer asynchronous cloud-platforms teledentistry solutions. Another teledentistry option is TeleDent by MouthWatch.

Robotic learned behaviors

The challenge is integrating and implementing current science, new ideas, philosophies, technologies and codes into our established systems. Once our school days are over, ongoing training can become inconsistent. Coding education and training is absent, erratic, hand-me-down and tradition-based. Once patterns are established, they seem rock solid and difficult to break.

It's somewhat like downhill skiing. On the first run, the powdery snow creates an amazing and enjoyable ride. The skier takes the run again and again and again. Over and over the pattern continues. Why? Because that skier gets comfortable with the run. Over time this snow becomes packed, weather changes and there is some melting and refreezing. What was a wonderful run can become a deep rut with icy sides. Attempts to scale up the sides of the rut can often lead to slipping right back into the rut.

It can feel daunting when there is also the perception of someone on the top of the rut kicking you back down. This describes the perception that many dental professionals have of dental benefit carriers. Strategic thinking, step-by-step planning and small daily choices can help break patterns and melt the icy sides.

Daily choices make the difference

New codes are not more numbers that become the responsibility of the practice business professionals to implement. These codes are game-changers that create opportunity for radical growth, change and profitability. In addition, these codes can help significantly move the needle to improve interdisciplinary health care and collaboration and ultimately patient health.

The question becomes: Where do you start? As the old saying about eating an elephant goes, you can only do it one bite at a time. It would be foolhardy to try to change everything at one time. Strategic planning is the key. Though common in many businesses, trade associations and more, the process is not frequently considered or implemented in dental practices.

It's easy to look back and see how big decisions have changed your life. What's harder to do is look back and realize how all those small everyday decisions have impacted you. In life, it's the daily small choices that make the most difference. There's a great quote by Wayne Dyer that goes, "Our lives are the sum total of the choices we have made." So, what kind of life are your everyday decisions making? Why does it take new codes for dentistry to change our deeply held behavior patterns? Codes are just numbers. Codes can provide opportunity. ■

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